U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 30 November 2005

In the Matter of

ALBERT L. RUSHBROOK

Claimant

v. Case No. 2004-BLA-06147

SHANNON POCAHONTAS MINING

Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,

Party-In-Interest

Appearances: James M. Phemister, Esq.
Erin Pride
Washington and Lee University Legal Clinic
For the Claimant

William S. Mattingly, Esq.
Jackson Kelly, PLLC
For the Employer

Before: William S. Colwell
Administrative Law Judge

DECISION and ORDER DENYING BENEFITS

INTRODUCTION

This proceeding arises from a claim for benefits under the Black Lung Benefits Act (the "Act"), 30 U.S.C. §§ 901 *et. seq*. Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners who were totally disabled due to pneumoconiosis at the time of their deaths (for claims filed prior to January 1, 1982), or whose death was due

to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a dust disease of the lungs resulting from coal dust inhalation. The Act and its implementing regulations define pneumoconiosis as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of employment in the Nation's coal mines. 30 U.S.C. § 902(b); 20 C.F.R. § 718.201 (2004). In this case, the Claimant, Albert L. Rushbrook, alleges that he is totally disabled by pneumoconiosis.

The Department of Labor has issued regulations governing the adjudication of claims for benefits arising under the Black Lung Benefits Act at Title 20 of the Code of Federal Regulations. The procedures to be followed and standards applied in filing, processing, adjudicating, and paying claims, are set forth at 20 C.F.R., Part 725, while the standards for determining whether a coal miner is totally disabled due to pneumoconiosis are set forth at 20 C.F.R., Part 718.

I conducted a formal hearing on this claim on October 7, 2004, in Pipestem, West Virginia. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges. 29 C.F.R. Part 18 (2004). At the hearing, Administrative Law Judge Exhibit ("ALJX") 1, Director's Exhibits ("DX") 1-42, Claimant's Exhibits ("CX") 1-5, 7-10 and Employer's Exhibits ("EX") 2, 4-8 were admitted into evidence without objection. The decisions whether to admit CX-6 and EX-1 and 3 were taken under advisement. The record was held open after the hearing to allow the parties to submit additional argument. The Employer was also granted leave to submit medical evidence in response to CX-9. I admit EXs-9 and 10. I also admit CX-6, EX-1, and EX-3. The Claimant and Employer have submitted their closing arguments, and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits admitted into evidence, the testimony at hearing, and the arguments of the parties.

PROCEDURAL HISTORY

This is Mr. Rushbrook's fourth claim for benefits under the Act.[1] The Claimant initially filed for benefits on August 19, 1979. DX-1. This claim was administratively denied on September 17, 1980, because it was found that the Claimant, who was still employed at the time, failed to establish total respiratory disability. DX-1. The Claimant took no further action on this claim.

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[1] The Claimant had filed an occupational disease claim with the State of West Virginia, and on February 6, 1979 received a 15% permanent partial disability award for occupational pneumoconiosis. DX-1. A vocational assessment conducted on February 26, 1990 described Claimant's job as a car dropper as "medium work." DX-2 at 8.

The Claimant filed his second claim for benefits on August 20, 1984. DX-2. This claim was denied by the District Director on November 14, 1984, because it was determined that the Claimant failed to establish any element of entitlement. DX-2 After the consideration of additional evidence, the District Director affirmed the denial on April 2, 1987. DX-2 The District Director evaluated additional evidence, and again reaffirmed the denial of benefits on August 24, 1987. DX-2 On November 17, 1987, the second claim was referred to the Office of Administrative Law Judges for a formal hearing. On August 22, 1988, this claim was abated pending an appeal by the Director of duplicate claims cases affected by the Board's decision in *Lukman v. Director*, *OWCP*, 10 B.L.R. 1-56 (1987), *aff'd* 11 B.L.R. 1-71 (1988) (*en banc*), *rev'd* 896 F.2d 1248, 13 B.L.R. 2-332 (10th Cir. 1990). DX-2 A hearing was finally scheduled in this claim for June 6, 1990. The Claimant appeared without counsel, and the hearing was continued for him to secure representation. This claim was denied by Decision and Order, filed on July 24, 1991. DX-2. Applying the "true doubt" rule, the administrative law judge found that the Claimant had established the existence of pneumoconiosis. He nevertheless denied benefits, because the Claimant failed to establish total respiratory disability. The District Director denied modification on July 22, 1992, and Mr. Rushbrook took no further action on this claim. DX-2.

The Claimant filed his third claim on May 14, 1997. DX-3 [1]. The District Director denied this claim on October 8, 1997, after finding that the Claimant failed to establish any element of entitlement. DX-3 [17]. This claim was referred for a formal hearing, and on May 6, 1999, a Decision and Order – Denial of Benefits, was filed with the District Director. DX-3. The administrative law judge found that the Claimant did not establish a material change in condition in this duplicate claim, because he failed to establish total respiratory disability on the basis of the newly submitted evidence. The Claimant appealed to the Benefits Review Board, which affirmed in an unpublished opinion. *Rushbrook v. Shannon Pocahontas Mining Co*., BRB No. 99-0915 BLA (May 22, 2000) (unpub.).

The Claimant filed this subsequent claim for benefits under the Act on January 7, 2002. DX-5. On June 19, 2003, after the initial development of the record, the District Director issued a *Schedule for the Submission of Additional Evidence*. DX-31. The District Director concluded that the Claimant would be entitled to benefits if a decision on the merits were issued at that time, and also determined that Shannon Pocahontas Mining had been correctly named as the responsible operator. On January 23, 2004, the District Director issued a *Proposed Decision and Order - Award of Benefits -- Responsible Operator*. DX-33. By letters, dated January 27, February 9 and February 18, 2004, the Employer and a claims representative for its carrier requested a formal hearing. DXs-34, 35, 38, 39. Pursuant to these requests, this claim was referred on April 19, 2004 to the Office of Administrative Law Judges for a formal hearing as noted above. DX-40.

APPLICABLE STANDARDS

Because Claimant filed this application for benefits after March 31, 1980, the regulations set forth at Part 718 apply. *Lane v. Union Carbide Corp*., 105 F.3d 166, 170 (4th Cir. 1997); *Saginaw Mining Co. v. Ferda*, 879 F.2d 198, 204, 12 B.L.R. 2-376 (6th Cir.1989). This claim is governed by the law of the United States Court of Appeals for the Fourth Circuit, because Mr. Rushbrook was last employed in the coal industry in the State of West Virginia, within the territorial jurisdiction of that court. *Danko v. Director*, *OWCP*, 846 F.2d 366, 368, 11 B.L.R. 2-157 (6th Cir. 1988). *See Broyles v. Director*, *OWCP*, 143 F.3d 1348, 1349, 21 B.L.R. 2-369 (10th Cir. 1998); *Kopp v. Director*, *OWCP*, 877 F.2d 307, 12 B.L.R. 2-299 (4th Cir. 1989); *Shupe v. Director*, *OWCP*, 12 B.L.R. 1-200 (1989) (*en banc*).

In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is a substantial contributor to his total respiratory disability. 20 C.F.R. §§ 718.1, 718.202, 718.203 and 718.204 (2004). *Lane*, 104 F.3d at 170. *See Mullins Coal Co., Inc. of Virginia v. Director, OWCP*, 484 U.S. 135, 141, 11 B.L.R. 2-1 (1987); *Jericol Mining, Inc. v. Napier*, 301 F.3d 703, 708, 22 B.L.R. 2-537 (6th Cir. 2002), *cert. denied*, 538 U.S. 906 (2003). *See also Roberts & Schaefer Co. v. Director, OWCP*, 400 F.3d 992, 998, __ B.L.R. ___ (7th Cir. 2005).

The Claimant has the burden of proving each element of entitlement to benefits by a preponderance of the evidence. *Director*, *OWCP v. Greenwich Collieries* [*Ondecko*], 512 U.S. 267, 18 B.L.R. 2A-1 (1994), *aff'g* . *Greenwich Collieries v. Director*, *OWCP*, 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993). The failure to prove any requisite element precludes a finding of entitlement. *Anderson v. Valley Camp of Utah*, *Inc*., 12 B.L.R. 1-111 (1989); *Perry v. Director*, *OWCP*, 9 B.L.R. 1-1 (1986) (*en banc*).

ISSUES

The following issues are before the undersigned for adjudication:

1. Whether this subsequent claim was timely filed.
2. Whether the Claimant has established a change in an applicable condition of entitlement.
3. If so, whether the Claimant has pneumoconiosis as defined in the Act and the regulations and whether his pneumoconiosis arose out of coal mine employment.
4. Whether the Claimant is totally disabled.
5. Whether any total respiratory disability is due to pneumoconiosis.

See DX-40; Tr. 43. At the formal hearing, counsel for the Employer stipulated to 34 years of coal mine employment and that Mr. Rushbrook has one dependent for

purposes of the augmentation of benefits. Tr. 7-8.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

FACTUAL BACKGROUND AND THE CLAIMANT'S TESTIMONY

Mr. Rushbrook was 83 years old at the time of the hearing. He continues to live with his wife, Helen Virginia. Tr. 28. They were married on August 24, 1946. He started working in the mines in March, 1939. The Claimant first worked as a "bone picker." His coal mine work was interrupted by service in the United States Army in World War II. After this, Mr. Rushbrook returned to coal mine employment, and was so occupied until 1984. During this later period, Mr. Rushbrook worked as a railroad car loader, handling over 30 cars per day. As part of this work, Mr. Rushbrook was also responsible for cleaning railroad cars as well as repairing holes that would develop in the cars. This work entailed climbing into cars and lifting. He would also clean railroad tracks near the tipple to facilitate the passage of a car. Tr. 32, 39. His coal mine work exposed him to a considerable amount of dust. Tr. 34.

Mr. Rushbrook now experiences trouble breathing. He is limited in his day-to-day activities, and can no longer carry out everyday chores and activities such as mowing the lawn. He said that he could walk only a relatively short distance, and then would be required to stop and rest to catch his breath.

SUBSEQUENT CLAIM MEDICAL EVIDENCE

Chest X-Rays

Ex. No.	X-Ray/Reading Dates	Physician	Credentials	Interpretation
DX-12	01-30-02/01-30-02	Forehand	B	no pneumoconiosis, quality 2
DX-12	01-30-02/03-01-02	Binns	B/BR	quality 2
DX-14	01-30-02/10-02-03	Wheeler	B/BCR[2]	quality 1, no pneumoconiosis
CX-7	01-30-02/08-26-04	Alexander	B/BCR[3]	1/1, quality 2

[2] Dr. Wheeler has also held teaching positions at the Johns Hopkins University Medical Institutions since 1968, holding his current position as Associate Professor of Radiology since 1974. DX-14.

[3] Dr. Alexander is also board-certified in nuclear medicine and radiology. From October 1988

DX-15	10-14-03/10-14-03	Hippensteel	B	quality 1, no pneumoconiosis
DX-16	10-14-03/10-24-03	Wheeler	B/BCR	quality 2, no pneumoconiosis
CX-3	10-14-03/07-29-04	Ahmed	B/BCR	1/1, quality 2
CX-4	10-14-03/08-02-04	Cappiello	B/BCR	1/1, quality 1
CX-5	10-14-03/07-30-04	Miller	B/BCR[4]	1/1, quality 1
CX-6	10-14-03/08-26-04	Alexander	B/BCR	1/1, quality 1

Pulmonary Function Test Evidence

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater

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until June 1990, he was an Assistant Professor of Radiology and Nuclear Medicine at the University of Maryland Medical System. He has lectured in radiology at the Uppsala University Medical College. CX-6. The employer has challenged the admission of this exhibit. Tr. 10. I admit this exhibit as within the evidentiary limitations. The employer submitted two interpretations of the October 14, 2003 x-ray. The Claimant has in turn submitted two rereadings of this film in rebuttal, and two readings as part of his affirmative case. The Secretary's regulations pertinently read:

> The claimant shall be entitled to submit, in rebuttal of the case presented by the party opposing entitlement, no more than one physician's interpretation of each chest X-ray, pulmonary function test, arterial blood gas study, autopsy or biopsy submitted by the designated responsible operator or the fund, as appropriate, under paragraph (a)(3)(i) or (a)(3)(iii) of this section and by the Director pursuant to § 725.406.

20 C.F.R. § 725.414(a)(2)(ii). Under the regulations, the Claimant would be entitled to submit one rereading of "each chest X-ray," and not a rereading of each x-ray interpretation. *Cf.* 20 C.F.R. § 725.414(a)(2)(i) (claimant entitled to submit in affirmative case no more than two "*interpretations*"). Thus, Dr. Alexander's rereading of the October 14, 2003 x-ray would exceed the evidentiary limitations. On this record, however, I find good cause for the admission of this x-ray interpretation. This matches the two readings of this film as part of the employer's affirmative case. The remaining interpretations of this film are admitted as part of the Claimant's affirmative case.

[4] Dr. Miller is also an Assistant Clinical Professor of Radiology at the College of Physicians and Surgeons of Columbia University. CX-5.

the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV). The quality standards for pulmonary function studies performed before January 19, 2001, are found at 20 C.F.R. § 718.103 (2000), while the standards applicable to tests administered after that date are set forth at 20 C.F.R. § 718.103 (2004) and Appendix B.

The Secretary's regulations allow for the review of pulmonary function testing by experts who can review the ventilatory tracings and determine the validity of a particular test. 20 C.F.R. §§ 725.414(a)(2)(ii), 725.414(a)(3)(ii). *See generally* 20 C.F.R. § 718.103 & Part 718, Appendix B; *Director, OWCP v. Siwiec*, 894 F.2d 635, 636, 13 B.L.R. 2-259 (3d Cir. 1990); *Ziegler Coal Co. v. Sieberg*, 839 F.2d 1280, 1283, 11 B.L.R. 2-80 (7th Cir. 1988). Thus, in assessing the probative value of a clinical study, an administrative law judge must address "valid contentions" raised by consultants who review such tests. *Dotson v. Peabody Coal Co.*, 846 F.2d 1134, 1137-38 (7th Cir. 1988); *Strako v. Ziegler Coal Co.*, 3 B.L.R. 1-136 (1981). *See also Siegel v. Director, OWCP*, 8 B.L.R. 1-156 (1985) (2-1 opinion with Brown, J., dissenting). *Accord*, *Winchester v. Director, OWCP*, 9 B.L.R. 1-177(1986). In assessing the weight of an expert's review of a clinical test, I must account for that expert's credentials. *See Worley v. Blue Diamond Coal Co.*, 12 B.L.R. 1-20 (1988).

The following chart summarizes the results of the pulmonary function studies available in connection with the subsequent claim. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 C.F.R. § 718.204(b)(2)(i) (2004).[5] *See Grundy Mining*

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[5] Assessment of the pulmonary function study results is dependent on the Claimant's height, which I find to be 64.5 inches for purposes of evaluating the pulmonary function studies. *See Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). **Error! Main Document Only.***See also Toler v. Eastern Associated Coal Corp*., 43 F.3d 109, 114, 19 B.L.R. 2-70 (4th Cir. 1995).

Moreover, the pulmonary function tables presented at Appendix B, 20 C.F.R. Part 718, show values for miners up to 71 years of age. For testing administered to the Claimant when he was older than 71 years, I will reference the values listed for a miner of 71 years of age and extrapolate from that point. For example, the qualifying FEV1 value for a 71-year old miner 64.5" tall is 1.44. Based on the variation of the FEV1 curves over changes in age for younger miners, I find that the qualifying values for this Miner range from 1.29 for age 80 and 1.26 for age 82. *See Fraley v. Peter Cave Coal Mining Co.*, BRB No. 99-1279 BLA, slip op. at 6 (Nov. 24, 2000) (unpub.) (citing *Hubbell v. Peabody Coal Co*., BRB No. 95-2233, slip op. at 7 n. 7

Co. v. Flynn, 353 F.3d 467, 471 n. 1, __ B.L.R. ___ (6th Cir. 2003); *Director, OWCP v. Siwiec*, 894 F.2d 635, 637 n. 5, 13 B.L.R. 2-259 (3d Cir. 1990).

Ex. No.	Date	Age	HT.	FEV_1	FVC	MVV	FEV_1/FVC	Qualify
DX-12	01-30-02	80	65"	1.72	2.65	66.46		No

Dr. Forehand administered this test. He noted "good" cooperation and comprehension in its performance, and concluded that the results showed an "obstructive ventilatory pattern." Tracings are attached.

DX-15	10-14-03	82	64"	1.65	2.61	59	63%	No
	(post-bronchodilator)				1.54	2.54	60%	No

The "spirometry data" were considered "acceptable and reproducible. Tracings accompany this test. Dr. Hippensteel interpreted the results as indicative of "minimal obstruction pre and post bronchodilator. MVV is moderately decreased with small, variable tidal volumes." "Lung volumes are normal ... [and d]iffusion is at lower limits of normal." DX-15.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled. The quality standards for arterial blood gas studies performed before January 19, 2001, are found at 20 C.F.R. § 718.105 (2000), while the quality standards for tests conducted subsequent to that date are set forth at 20 C.F.R. § 718.105 (2004). The following chart summarizes the arterial blood gas studies available in this case. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b) (2000); 20 C.F.R. § 718.105(b) (2004).

The following arterial blood gas study evidence has been admitted into the record.

(Dec. 20, 1996) (unpub.)).

Ex. No.	Date	Physician	Alt.	pCO2	pO2	Qualify
DX-12	01-30-02	Forehand	<2999	39 34	68 61	No Yes (exercise)
DX-15	10-14-03	Hippensteel		40.5	64.6	No

Dr. Forehand interpreted the results as showing "hypoxemia at rest and with exercise [with] no metabolic disturbance." DX-12. Dr. Dominic Gaziano reviewed this test and concluded that it was "technically acceptable." DX-12.

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, and whether the miner is totally disabled. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 C.F.R. § 718.202(a)(4) (2004). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). *See Martin v. Ligon Preparation Co.*, 400 F.3d at 306. The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 C.F.R. § 718.202(a)(4) (2004).

Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 C.F.R. § 718.204(b)(2)(iv) (2004). With certain specified exceptions, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 C.F.R. § 718.204(c)(2) (2004). Quality standards for reports of physical examinations performed before January 19, 2001, are found at 20 C.F.R. § 718.104 (2000), while the applicable standards for physical examinations coming after that date are set forth at 20 C.F.R. § 718.104 (2004).

The subsequent claim record contains the following medical opinions relating to this case.

Dr. J. Randolph Forehand

Dr. Forehand examined the Claimant on January 30, 2002 at the request of the Department of Labor. DX-12. He noted that the Claimant's last coal mine job duties required the Claimant to operate chutes to put coal in cars, shovel coal, carry upwards of 100 pounds and travel over 400 steps a day. Dr. Forehand recorded a patient medical history of arthritis, heart disease and high blood pressure. Hospitalizations included a stay for a quadruple bypass in 1997 and esophageal stricture in 1992. Mr. Rushbrook's smoking history was recorded as 44 years at the rate of one pack per day.

Mr. Rushbrook presently complained of a daily cough productive of "glue-looking phlegm," wheezing with any exercise and dyspnea with walking and climbing stairs. On physical examination, Dr. Forehand detected no dullness on percussion of the chest, and observed "scattered wheezes" on auscultation. There were no positive signs on examination of the extremities.

Dr. Forehand incorporated the results of a chest x-ray, ventilatory and arterial blood gas tests, and an EKG. The x-ray showed no pneumoconiosis. The pulmonary function test demonstrated an obstructive ventilatory pattern, while the arterial blood gas test results showed "hypoxemia at rest and with exercise [with] no metabolic disturbance." A treadmill test was terminated due to "short[ness] of breath."

Dr. Forehand diagnosed "chronic bronchitis," which was explained by patient history, the negative x-ray, pulmonary function and arterial blood gas testing. He attributed this to the Claimant's "cigarette smoking." He also concluded that a "significant respiratory impairment is present [with] insufficient residual ventilatory and gas exchange capacity remain[ing] to return to his last coal mining job. Unable to work. Totally and permanently disabled." Dr. Forehand attributed this total respiratory disability solely to the Claimant's chronic bronchitis. DX-12.

Dr. Kirk E. Hippensteel

Dr. Hippensteel examined Mr. Rushbrook on October 14, 2003. His report was submitted on November 24, 2003. DX-15. He recorded a coal mine employment history of 44 1/2 years, and was told that all of this work was outside. Mr. Rushbrook told Dr. Hippensteel that his work required him, *inter alia*, to pull railroad cars using a chain that weighed 100 pounds. The Claimant related to Dr. Hippensteel that he could only walk about 25 feet before getting short of breath, and that he could not climb stairs. He also told the doctor that "he cough[ed] up less than one teaspoon of white to yellow sputum per day." He also said that he uses one pillow to sleep, and does not have to use inhalers at night, although he uses two inhalers two to four times each day. Mr. Rushbrook said that he had smoked for 44 years at the rate of one-half pack per day.

Dr. Hippensteel conducted a physical examination, and was aided by clinical testing. He said that a chest-x-ray was negative for pneumoconiosis, that spirometry "show[ed] minimal obstruction pre and post bronchodilator [with] MVV ... moderately decreased with small variable tidal volumes indicative of suboptimal effort[.]" Dr. Hippensteel reported that the lung volumes were "normal." The "diffusion [was] at lower limits of normal with 75% of predicted."

Based on his examination, Dr. Hippensteel concluded:

> The data from this examination show ... no evidence of coal workers' pneumoconiosis and no clinically significant pulmonary dysfunction. His arterial blood gases are actually within normal limits for his age with the lower limit of normal at this barometric pressure equal to 61. ... [E]ven though his arterial blood gases meet criteria for pulmonary impairment ... an 82-year-old man would meet criteria for disability ... even with normal gas exchange for his age.

DX-15.

Dr. Hippensteel also reviewed the Claimant's medical records, including other reports. Based on this review, he concluded that the Claimant does not have pneumoconiosis, but that he as "developed variable obstructive airways disease, not typical for coal workers' pneumoconiosis since it produces a fixed or progressive impairment." Dr. Hippensteel also concluded that Mr. Rushbrook "had developed chronic bronchitis, which is not in keeping with industrial bronchitis from his coal dust exposure, since it had been a long number of years since he worked in the mines[.] ... [T]he records show with a reasonable degree of medical certainty that this man would have been just as ill from the same problems had he never stepped foot into a coal mine." He discounted Dr. Rasi's opinion, because that physician's diagnosis of disabling coal workers' pneumoconiosis failed to address "other issues that could cause shortness of breath, including his coronary artery disease and his significant cigarette smoking history."

Dr. Hippensteel is board-certified in internal medicine and pulmonary disease, and is a B-reader. DX-15.

Dr. Ben V. Branscomb

Dr. Branscomb conducted an evaluation of Mr. Rushbrook's medical records, and interpreted a CT scan. EX-6. He assumed a coal mine employment history of 39 years until the Claimant's retirement from the mines in 1984. He also recorded a lengthy cigarette smoking history, with reports that Mr. Rushbrook began smoking at age 14 or 15. Dr. Branscomb said in this regard that the "adverse effects of tobacco on the lungs does not stop with cessation of smoking but continues to progress although at

a slower rate than when smoking is continued." EX-6 at 2.

Dr. Branscomb then explained his survey of the Claimant's medical records. For purposes of this subsequent claim, we will confine this preliminary discussion to Dr. Branscomb's evaluation of the medical evidence that was developed subsequent to the Board's affirmance of the denial of Mr. Rushbrook's prior claim.

Based on this review, Dr. Branscomb concluded:

> I concur in the medical opinion that simple CWP is sometimes disabling, that CWP can be a progressive disorder first manifest after mining stops, that its manifestations may be latent, and that sometimes coal mine dust or CWP produce obstructive manifestations. I also incorporate in my definition of CWP for this report the concept that any pulmonary disorder or impairment in any way caused or significantly aggravated by either coal mine dust or CWP is regarded as pneumoconiosis. Further, I accept the concept that disability caused by a non-occupational disorder which has been materially worsened by either coal mine dust or CWP is included as a disability attributable, at least in part, to CWP.
>
> * * *
>
> There is no objective evidence to justify a diagnosis of clinical or legal CWP in Mr. Rushbrook. He has no persisting chronic impairment that could be attributed to COPD or CWP. He may have intermittent manifestations of chronic bronchitis with intermittent transient reductions in PO2. If he does this is not disabling, has developed long after his exposure to coal mine dust, and is the result of his severe esophageal disease and smoking. He is not disabled as a result of any pulmonary disease. He probably is disabled as the result of age, coronary disease, and orthopedic disease. These are neither caused nor aggravated by the effects of coal dust.
>
> If I assume he does have CWP I would still conclude he is not disabled from his previous coal mine work by virtue of any pulmonary disease and that any pulmonary impairment is intermittent and is the consequence of a mild intermittent bronchitis from his GI disease and chronic aspiration.

EX-6. Dr. Branscomb is board certified in internal medicine, is currently a Professor Emeritus of the University of Alabama at Birmingham, and has a distinguished academic and clinical career in the fields of internal and pulmonary medicine. EX-7.

Dr. Steven M. Koenig

Dr. Koenig conducted a detailed review of the Claimant's medical records, and submitted his report of this evaluation on September 16, 2004. CX-9. Dr. Koenig recorded a coal mine employment history of 36 years. He also reviewed the exertional requirements of Mr. Rushbrook's last coal mine work as railroad car loader. Dr. Koenig also reported a cigarette smoking history of 48 years at the rate of one to one and one-half pack per day.

Dr. Koenig concluded, *inter alia*, that:

* * *

> 2. Mr. Rushbrook has pulmonary impairment secondary to obstructive lung disease, and it is totally and permanently disabling from his respiratory disease. My conclusion would be the same even if I used Dr. Hippensteel's inappropriately low predicted normal values for pulmonary function testing.
>
> 3. Mr. Rushbrook has coronary artery disease and had a myocardial infarction. However, even without this cardiac history, Mr. Rushbrook's pulmonary impairment is of sufficient severity to render him totally and permanently disabled.
>
> 4. Chronic obstructive pulmonary disease (COPD), which includes chronic bronchitis and emphysema, is the cause of this obstructive lung disease. Mr. Rushbrook does not have asthma.
>
> 5. Coal dust exposure, without the presence of radiographically evident simple or complicated coal workers' pneumoconiosis, caused [Mr.] Rushbrook's COPD and consequent respiratory impairment and total and permanent disability. Although Mr. Rushbrook did smoke cigarettes, the accelerated decline in lung function noted after cessation of smoking indicates that coal dust exposure was the cause of his COPD. At the very least, coal dust exposure contributed significantly to Mr. Rushbrook's COPD.
>
> 6. To claim that Mr. Rushbrook's respiratory disability could not be secondary to coal dust exposure would be disregarding numerous methodologically valid studies in the medical literature[.] Moreover, in the absence of other causes of Mr. Rushbrook's accelerated decline in lung function after he quit smoking, there is no other logical or scientifically valid explanation.

CX-9. Dr. Koenig is board-certified in internal medicine with subspecialties in

pulmonary disease, critical care medicine and sleep medicine. He has been a Professor of Medicine at the University of Virginia School of Medicine since July, 2004. Prior to that time he was an Assistant Professor of Medicine from October 1994 to June 1999 and then Associate Professor of Medicine from July 1999 to June 2004. CX-10.

Supplemental Reports

Dr. Hippensteel submitted a supplemental report by leave of the undersigned in response to the medical review by Dr. Koenig. EX-10. I admit this report as rebuttal, which responds to criticism raised by Dr. Koenig's medical report. 20 C.F.R. § 725.414(a)(3)(ii).

Dr. Hippensteel took issue with Dr. Koenig's statement that the pulmonary function test that was conducted by him did not indicate which criteria had been used for the predicted values. In fact, the ventilatory test report indicates "Morris/Polger" reference values. He also noted that Dr. Koenig had referenced a lifting requirement of "100 pounds" in calculating a VO2 max calculation, when Mr. Rushbrook had told Dr. Hippensteel that he was required to lift 50 pounds, although he had said that he pulled railroad cars using a 100 lb. chain. Dr. Hippensteel disagreed with Dr. Koenig's statement that coronary artery disease does not cause abnormalities on ventilatory testing.

At bottom, Dr. Hippensteel explained:

> I disagree with Dr. Koenig's conclusions because this man demonstrated variable rather than fixed obstructive disease. I would also note that obstructive disease in cigarette smokers is even more progressive than simple coal workers' pneumoconiosis, which Dr. Koenig negates in his comments. As stated in my ... report, this man is disabled because of his age. It cannot be concluded that this man has coal workers' pneumoconiosis rather than obstructive disease from his cigarette smoking from the data available in this man's medical records in spite of Dr. Koenig's assertions otherwise.

EX-10.

Dr. Branscomb also submitted a supplemental report, dated October 28, 2004, by leave of the undersigned in response to the medical review by Dr. Koenig. EX-9. 20 C.F.R. § 725.414(a)(3)(ii). Dr. Branscomb disagrees with Dr. Koenig's analysis and conclusions. While Dr. Koenig noted that the West Virginia CWP Board reported shortness of breath in 1977, Dr. Branscomb retorted that "there were numerous well-documented examinations including such major events as coronary bypass surgery during which there was no mention of any significant respiratory symptoms." Dr. Branscomb further observed that "[i]t is medically unreasonable to conclude that significant shortness of breath could have been overlooked." He added that "pulmonary

function was entirely normal at least as late as the test of Dr. Rasmussen in 1990."

Dr. Branscomb acknowledged the latent effects of coal mine dust inhalation. He opined, however, that "there is no scientific documentation that a clinically significant or disabling level of pulmonary impairment could develop as a consequence of coal dust exposure in a worker with those normal values, so long following retirement." Dr. Branscomb also discounted Dr. Koenig's "tabulat[ion]" of clinical results without "commen[ing] on their individual validity, nor the circumstances under which they were obtained."

Dr. Branscomb refuted Dr. Koenig's diagnosis of COPD:

> Dr. Koenig feels there is indisputable evidence of COPD. I do not agree. The records do not document the pattern of cough and expectoration required for the diagnosis. Furthermore, there was no measurable obstruction as late as 10-14-03. Noting Dr. Hippensteel's normal FEV1 in spite of Mr. Rushbrook's severe esophageal disease and devastating smoking history, it is surprising that he did not have significant chronic airway obstruction. Note, one cannot conclude that there is obstructive disease by the FEV1/FVC – when both are normal. As noted, I disagree that there is significant chronic impairment in diffusing capacity.
>
> I disagree that coronary artery disease, myocardial infarction (and esophageal disease) do not represent causes of pulmonary function impairment as asserted by Dr. Koenig. Esophageal disease is a major cause of pulmonary impairment.
>
> * * *
>
> In my judgment, the medical records objectively establish the absence of impairment from any chronic pulmonary disease sufficiently severe to prevent Mr. Rushbrook's last employment of one year's duration. He does not have clinical or legal pneumoconiosis.

EX-9.

Physician Deposition Testimony

Dr. Kirk E. Hippensteel

Dr. Hippensteel's deposition testimony was recorded on September 15, 2004 and introduced as EX-8. Dr. Hippensteel is board certified in internal medicine, pulmonary disease and critical care medicine. DX-15; EX-8 at 5. He is also a B-reader. EX-8 at 6.

Dr. Hippensteel first testified about his examination of the Claimant on October 14, 2003. He reiterated that, in his view and based on the examination and a review of

other records, Mr. Rushbrook does not have pneumoconiosis, or a chronic coal mine dust-induced lung disease. EX-8 at 8. With respect to an assessment of disability, the following exchange took place:

> Q And did he retain the capacity from a pulmonary standpoint to perform the rigors associated with his last coal mining job?
>
> A Well, as I stated in my report, as an 82-year-old man, he does not have the capacity to return to his job in the mines, and that even includes his pulmonary capacity, because his gas exchange is decreased from normal, or I should say is decreased from what expect a person of working age to have, but it is in the normal range for an 82 year old.

EX-8 at 9.

Dr. Hippensteel acknowledged that Mr. Rushbrook had a significant coal mine dust exposure. He thought that the Claimant's heart disease and deconditioning "mostly caused" the Claimant's shortness of breath. He emphasized that the inhalers that have been prescribed for Mr. Rushbrook are not useful for treating coal mine dust-induced diseases, because

> [t]he inflammation that occurs from coal mining dust is something that produces a fixed impairment and is not responsive to bronchodilators unless one would be talking about industrial bronchitis, which I think is excluded in this man because he had been out of the mines since 1984, and industrial bronchitis, from such exposure, is something that usually subsides within a period of several months after leaving such exposure.

EX-8 at 12-13.

Dr. Hippensteel had recorded a smoking history of 44 years at the rate of one-half pack per day.

When asked about positive x-ray interpretations, with findings of opacities in the lower lung zones, Dr. Hippensteel opined that pneumoconiosis "is predominantly in the upper lung zones" although it can involve the lower area. EX-8 at 17. He also explained that "people that have had coronary bypass surgery frequently have increased markings in their lower lung zones referable to having had such surgery[.]" Dr. Hippensteel also thought that the Claimant's age could be a factor in the presence of increased markings. EX-8 at 18.

The results of the pulmonary function testing that Dr. Hippensteel conducted during the evaluation suggested a "minimal air flow obstruction ... [that] ... didn't change significantly postbronchodilator." He thought the test finding was not clinically significant, and that the test suggested a "small airways dysfunction" with a "minimal

amount of air flow obstruction[.]" EX-8 at 20. Dr. Hippensteel thought that the lung volumes were normal. He also opined that the arterial blood gas studies do not show any permanent or progressive abnormality. EX-8 at 23. He noted that Mr. Rushbrook had evidence of chronic bronchitis that can cause a variability in gas exchange. He further said

> [B]ut certainly, he did not have any permanent gas exchange impairment or a diffusion impairment that would be expected to cause a permanent change to make me think that this was coming from intrinsic lung disease caused by his coal mine dust exposure.
>
> * * *
>
> ... I think that one would expect the gas exchange impairment to be steady and fixed rather than variable. I would expect that his gas exchange impairment would be associated with a diffusion impairment, which was not the case in this man either, so I didn't think that it was consistent with causation from his coal mine dust exposure.

EX-8 at 23. He also disagreed with views attributed to Dr. Rasmussen on the subject, and stated that "in general, it is expected that ventilatory impairment is also present at the time of that gas exchange impairment if it relates to coal workers' pneumoconiosis." EX-8 at 24.

Dr. Hippensteel was asked about whether smoking would be the explanation for the results in the clinical testing. He responded that it would be "a little difficult to pick up whether some of the abnormalities [that are] tied in with his chronic bronchitis from his cigarette smoking[.]" He noted as well that a third factor [in addition to smoking and coal mine dust exposure is the Claimant's] significant heart disease that can also cause variability in gas exchange from time to time." EX-8 at 25.

Dr. Hippensteel was vigorously cross-examined. He was questioned at length about the predicted values or standards for pulmonary function studies that were the predicate for his disability assessment. This gist of this cross-examination appears to be that with the use of different criteria or predicted values for ventilatory testing, Dr. Hippensteel's assessment may well be undermined by the fact that under some "predicteds," *i.e.* predicted values, a particular pulmonary function result would indicate a greater degree of disability.

Dr. Hippensteel was also asked about positive x-ray interpretations that he had not reviewed. He was then asked whether he could rule out the existence of pneumoconiosis based on the x-ray evidence. Dr. Hippensteel responded:

> I would state that you could in this circumstance, because if you had x-ray readings that were read as consistent with pneumoconiosis for,

> say, five straight years, and then you had an x-ray that became clear, I think that one could state that unequivocally, that the x-ray evidence that was read as positive earlier in the case did not refer to coal workers' pneumoconiosis, because coal workers' pneumoconiosis does not spontaneously resolve itself, so I think that there are circumstances where you can have the overwhelming majority of evidence be read as something abnormal about the x-ray that could be consistent with pneumoconiosis that would turn out to be not pneumoconiosis at all.

EX-8 at 38. Dr. Hippensteel also testified that, with respect to a positive interpretation on an "ILO" form, that

> [a]ll we are saying when we fill out an ILO form is that it could be consistent with pneumoconiosis, and that means all kinds, including those that are basilar predominant as well as those that are occurring more predominantly elsewhere in the lungs.
>
> When one says that, that it could be from that, that doesn't mean that you've made a diagnosis of pneumoconiosis; you've said that the findings could be referable to it, it could be consistent with it, so again, I would differ with your statement to say that they found evidence that showed that this was pneumoconiosis, just by having a positive profusion on an x-ray.

EX-8 at 36-37.

Treatment Records

Dr. Anthony D. Rasi authored a brief later report on March 24, 2003. DX-13. He said that he has been the Claimant's treating physician since November 11, 1981, and noted that Mr. Rushbrooks's "breathing has become progressively worse ... his exertional dyspnea is more pronounced." Dr. Rasi also noted that Mr. Rushbrook "has been afflicted with coal miner's pneumoconiosis[.]" DX-13.

Dr. Michael S. Alexander

Dr. Alexander interpreted a CT Scan that had been taken on December 16, 1999. CX-8. He opined that the CT scan "is inadequate and unacceptable for establishing or excluding the diagnosis of simple Coal Worker's Pneumoconiosis."

DISCUSSION

Timeliness

Section 728.308 of the Secretary's regulations in part sets forth a rebuttable presumption that every claim for benefits is timely. 20 C.F.R. § 725.308. I find that this presumption has not been rebutted by evidence of record. The purpose of the Regulation allowing the filing of subsequent claims is "to provide relief from the ordinary principles of finality and res judicata to miners whose physical condition deteriorates." *Lukman v. Director, OWCP*, 896 F.2d 1248, 1253, 13 B.L.R. 2-232 (10th Cir. 1990). Although the parties have addressed the stringent prescription analysis adopted by the Sixth Circuit in *Tennessee Consolidated Coal Co. v. Kirk*, 264 F.3d 602, 22 B.L.R. 2-288 (6th Cir. 2001), that decision does not govern the adjudication of the timeliness issue in this case, which is governed by the law the Fourth Circuit.

The effect of the denial of Mr. Rushbrook's third claim, based on the finding that he failed to establish entitlement, "repudiates any earlier medical determination [that the Claimant is totally disabled due to pneumoconiosis] and renders prior medical advice to the contrary ineffective to trigger the running of the statute of limitations [of 20 C.F.R. § 725.308]." *Westmoreland Coal Company v. Amick*, No. 04-1147, slip op. 8 (4th Cir. Dec. 6, 2004) (unpub.) (quoting *Wyoming Fuel Company v. Director*, *OWCP*, [*Brandolino*], 90 F.3d 1502, 1507, 20 B.L.R. 2-302 (10th Cir. 1996)). The prescriptive periods of the Act, 30 U.S.C. § 932(a) and 20 C.F.R. § 725.308 would not have begun to run until after that point. The instant claim, filed within three years of the point at which the prior denial became final, is thus timely.

"Material Change in Conditions"

After the expiration of one year from the denial of the previous claim, a subsequent claim must be denied on the basis of the prior denial unless a miner demonstrates with the submission of additional material that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. 20 C.F.R. § 725.309(d)(2004).

To assess whether this change is established, the administrative law judge must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. *See Lisa Lee Mines v. Director, OWCP* [*Rutter*], 86 F.3d 1358, 1362-63, 20 B.L.R. 2-227 (4th Cir. 1996) (en banc), *cert. denied*, 519 U.S. 1090 (1997). The Board has ruled that the focus of the material change standard is on specific findings made against the miner in the prior claim; an element of entitlement which the prior administrative law judge did not explicitly address in the denial of the prior claim does not constitute an element of entitlement "previously adjudicated against a Claimant." *See Allen v. Mead Corp.*, 22 B.L.R. 1-63 (2000) (*en banc*). If a Claimant establishes the existence of that element, he has demonstrated, as a matter of law, a change in the

applicable conditions of entitlement in a subsequent claim, and would then be entitled to a full adjudication of his claim based on the record as a whole. *See Rutter*, 86 F.3d at 1362-63. *See Allen v. Mead Corp.*, 22 B.L.R. 1-63 (2000) (*en banc*); *Cline v. Westmoreland Coal Co.*, 21 B.L.R. 1-69 (1997).

Total Respiratory Disability

In this case, the previous claim was denied because the Claimant failed to establish total respiratory disability. Accordingly, the Claimant may establish a change in an applicable condition of entitlement by proving that element.[6]

The Claimant must establish he is totally disabled due to pneumoconiosis in order to be eligible for benefits under the Act. *See Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994). A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304, or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR §§ 718.204(a), (b) and (c). I emphasize that *any* loss in lung function may qualify as a total respiratory disability under Section 718.204(a). *See Carson v. Westmoreland Coal Co.*, 19 B.L.R. 1-16 (1964), *modified on recon*. 20 B.L.R. 1-64 (1996).

The Regulations provide a number of methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 C.F.R. §§ 718.204(b)(2) and (d) (2004). I must weigh all of the relevant probative evidence which meets one of the four medical standards applicable to living miners under Section 718.204(b)(2). *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195 (1986), *aff'd on recon.,* 9 B.L.R. 1-236 (1987)(*en banc*). In the absence of contrary probative evidence, evidence which meets one of the Section 718.204(b)(2) standards shall establish Claimant's total disability.[7] *See Fields v. Island Creek Coal*

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[6] Although the administrative law judge found that the Claimant had proven the existence of pneumoconiosis in the initial administrative decision on the second claim, this finding was based on the now abrogated "true doubt" rule. DX-2. Further, the Fourth Circuit has changed its interpretation of the law with respect to the analysis at Section 718.202(a) for determining whether a miner has proven the existence of pneumoconiosis. The adjudicator must weigh all of the evidence together in reaching a finding as to whether a miner has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211, 22 B.L.R. 2-162 (4th Cir. 2000). *See Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 21 B.L.R. 2-104 (3rd Cir. 1997). Nevertheless, for purposes of evaluating the subsequent claim evidence, the undersigned will treat the existence of pneumoconiosis as correctly established in the prior claims.

[7] Lay testimony may also constitute relevant evidence. *See Madden v. Gopher Mining Co.*, 21

Co., 10 B.L.R. 1-19 (1987).

20 C.F.R. § 718.204(b)(2)(i)

I find that the Claimant has not demonstrated total respiratory disability on the basis of the newly submitted pulmonary function study results. The values achieved on the tests administered by Drs. Forehand and Dr. Hippensteel do not produce qualifying values.

20 C.F.R. § 718.204(b)(2)(ii)

I also find that, on balance, the newly submitted arterial blood gas study results do not demonstrate total respiratory disability. Although the post-exercise results obtained by Dr. Forehand qualify, DX-12, the relevant blood gas study results at most are equally probative.

20 C.F.R. § 718.204(b)(2)(iii)

There is no evidence that the Claimant is afflicted with cor pulmonale with right-sided congestive heart failure. I therefore find that he has not demonstrated total respiratory disability at Section 718.204(b)(2)(iii).

20 C.F.R. § 718.204(b)(2)(iv)

For the reasons that follow, I do find that total respiratory disability has been demonstrated at Section 718.204(b)(2)(iv) on the basis of the medical opinion evidence in the subsequent claim record.

In sum, Drs. Forehand and Koenig assess the Claimant as totally disabled from a pulmonary of respiratory standpoint. DX-12; CX-9. Dr. Rasi, in a brief letter, commented that he had observed that the Claimant had a "long-standing history of chronic obstructive pulmonary disease ... with some respiratory insufficiency." DX-13. The opinions of Drs. Forehand and Koenig thus support a finding of total respiratory disability. I note Dr. Rasi's recollection that the Claimant suffers from a "long-standing history of chronic obstructive pulmonary disease[,]" and his observation that his breathing has become progressively worse. DX-13. Although his brief letter by itself is not a particularly probative document with respect to the diagnosis of pneumoconiosis or assessment of pulmonary or respiratory impairment, unless he has misrepresented his observations during his long-term treatment of Mr. Rushbrook, Dr. Rasi's observations provide additional support for the case that the Claimant suffers from a total respiratory disability.

B.L.R. 1-122 (1999). A finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony, however. 20 C.F.R. § 718.204(d) (2002). *See Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994).

Although Dr. Hippensteel does not believe the Claimant is totally disabled from a pulmonary or respiratory standpoint, I do not find that his opinion, at least with respect to this point, greatly undermines the probative value of those opinions that the Claimant is so disabled. Dr. Hippensteel opined that Mr. Rushbrook is disabled because of his age, EX-10, and stated that there is no evidence of a clinically significant pulmonary dysfunction. DX-15. In his deposition testimony, however, Dr. Hippensteel said at one point that Mr. Rushbrook "does not have the capacity to return to his job in the mines, and that even includes his pulmonary capacity[.]" EX-8 at 9.

Dr. Branscomb denied the presence of a totally disabling pulmonary or respiratory impairment, and I have duly considered his assessment that the Claimant is not totally disabled by a pulmonary or respiratory impairment. EX-9. I have also considered his observation that the record does not "document a pattern of cough and expectoration" that would be required for Dr. Koenig's diagnosis of COPD.

In the final analysis, I find that the newly submitted medical opinion evidence demonstrates the presence of a totally disabling pulmonary or respiratory impairment, irrespective of etiology. Any loss in respiratory capacity or lung function may qualify as a pulmonary or respiratory disability, whether it is derived from the Claimant's coronary disease, deconditioning, esophageal disease, or age. Dr. Hippensteel would certainly insist that the Claimant does not suffer from a totally disabling pulmonary or respiratory impairment in the conventional sense, and I do not find otherwise. Similarly, Dr. Branscomb's conclusions are that the Claimant is not totally disabled. But even he has suggested that esophageal disease may be a major cause of pulmonary impairment. Finally, the Claimant's testimony at this point is relevant, and I credit his representations that he has trouble breathing and that this affects the performance of his day to day activities.

Because the cause of any pulmonary disability is not a factor at Section 718.204(a), such opinions, that the Claimant's age, deconditioning or smoking are the sources of any respiratory insufficiency, do not undermine a finding of total disability at Section 718.204(b)(2)(iv).

Fields – Shedlock Analysis

The final step is to determine whether the evidence establishes that the Claimant suffers from a totally disabling pulmonary or respiratory impairment. *See Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195 (1986), *aff'd on recon.,* 9 B.L.R. 1-236 (1987)(*en banc*). *See generally Poole v. Freeman United Coal Mining Co.*, 897 F.2d 888, 894, 13 B.L.R. 2-348 (7th Cir. 1990). Although the non-qualifying arterial blood gas tests, ventilatory tests, and the opinions from Drs. Hippensteel and Branscomb constitute contrary probative evidence, I am persuaded by the medical opinions of Drs. Koenig and Forehand, as well as the qualifying arterial blood gas result, that Mr. Rushbrook does not have the pulmonary or respiratory capacity to return to his

previous coal mine employment. I therefore find that he has established total respiratory disability, a condition of entitlement previously adjudicated against him. 20 C.F.R. § 718.204(a).

Merits of Entitlement

In view of this finding, I conclude that the Claimant is entitled to an adjudication of this subsequent claim on the basis of the record as a whole.[8] *See Lisa Lee Mines v. Director, OWCP* [*Rutter*], 86 F.3d at 1362-63.

The earlier record contains interpretations of a CT scan taken on December 16, 1999. CXs-1, 8; EXs-1, 3, 5, 6. Dr. Aycoth found "benign post surgical coronary artery bypass changes," but otherwise the CT was "unremarkable." CX-1 at 24. Drs. Scott and Wheeler did not find pneumoconiosis on the basis of this CT scan. Dr. Alexander asks us to disregard the CT scan, concluding that a test of this nature lacks probative value and neither supports nor disproves the existence of pneumoconiosis. I defer to the interpretations by Drs. Scott and Wheeler. These radiologists as radiologists are well qualified, and I shall assume that they would not have rendered their opinions unless they considered the CT scan to be a legitimate diagnostic tool.

Dr. German Iosif

Dr. Iosif examined the Claimant on September 1, 1998. DX-3 [EX-4]. He also evaluated the Claimant's records. Based on this examination and review, Dr. Iosif diagnosed COPD with chronic bronchitis, coronary artery disease and hearing loss. He considered the Claimant is totally disabled due to his coronary artery disease. He did not believe that the Claimant's respiratory condition and related impairment are related to Mr. Rushbrook's occupational dust exposure. He thought that the Claimant's pulmonary or respiratory impairment has not progressed, and opined that it likely would be "explained by the discontinuation of cigarette smoking in 1982, allowing for the stabilization of the claimant's COPD."

Dr. C. P. Vasudevan

Dr. Vasudevan examined the Claimant for the Department of Labor on June 27, 1997. DX-3 [DX-13]. He diagnosed arterial sclerotic heart disease, hypertension and COPD. The smoking was attributed to COPD. He did not assess the Claimant as totally disabled.

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[8] Although all of the record is to be reviewed *de novo*, the evidence that was previously reviewed by other adjudicators and previously set forth will not again be listed herein in great detail unless necessary for a consideration of an issue. Without adopting earlier findings and conclusions by those tribunals, I do incorporate by reference those lists of exhibits and evidence as previously set forth. *See generally*, *Wheeler v. Apfel*, 224 F.3d 891, 895 n. 3 (8th Cir. 2000).

Deposition of Dr. Donald L. Rasmussen

Dr. Rasmussen's deposition was recorded on October 1, 1998. DX-3 [CX-2]. He is board-certified in internal medicine and pulmonary disease. Dr. Rasmussen opined that presence of two risk factors for the development of Mr. Rushbrook's "mild to moderate impairment" in respiratory function – his significant cigarette smoking history and coal mine dust exposure. DX-3 [CX-2] at 6. He testified that he would not be able to diagnose pneumoconiosis but for positive x-ray evidence of the disease. *Id*. at 9. He emphasized that the smoking is a significant contributing factor. He also considered coal mine dust exposure a significant contributory factor.

Treatment Records

Dr. Brian M. Strain, a cardiologist, reported on April 2, 1997 that Mr. Rushbrook had undergone quadruple coronary artery bypass graft surgery on February 26, 1997. He reported in this letter that "Mr. Rushbrook has a long-standing history of chronic obstructive pulmonary disease and [that he] was actually hospitalized ... after his bypass surgery for approximately six days with some respiratory insufficiency." DX-13. In an earlier letter, dated March 3, 1997, Dr. Strain noted that Mr. Rushbrook's history included "pneumoconiosis and chronic obstructive pulmonary disease." DX-13.

Total Respiratory Disability

Upon review of the record as a whole, and for the reasons as set forth in the above subsequent claim analysis, I find that the Claimant has established that he suffers from a totally disabling pulmonary or respiratory impairment. I have accounted for the tests and medical opinions that accompanied Mr. Rushbrook's earlier claims for benefits, and duly note that they have not, on balance, established total respiratory disability. Applying the subsequent claim analysis, however, I credit the more recent disability assessments by Drs. Forehand and Koenig. I note that, given the progressive nature of pneumoconiosis, *see Eastern Associated Coal Corporation v. Director, OWCP*, 220 F.3d 250, 258 (4th Cir. 2000), the more recent evidence with respect to the nature and extent of the Claimant's pulmonary or respiratory *disability* would be the more probative of his condition at the time of the hearing. *See Cooley v. Island Creek Coal Co.*, 845 F.2d 622, 11 B.L.R. 2-147 (6th Cir. 1988). *See also Wetzel v. Director, OWCP*, 8 B.L.R. 1-139 (1985).

Although the medical opinions from Drs. Hippensteel and Branscomb, as well as the non-qualifying clinical tests that were administered for the subsequent claim and the earlier claims constitute contrary probative evidence, and while I have carefully reviewed the evidence from the prior claims, this more recent evidence of total respiratory disability carries considerable weight.

The Claimant has established this element of entitlement. 20 C.F.R. § 718.204(a).

Pneumoconiosis

Although the existence of pneumoconiosis was established earlier, collateral estoppel will not obtain to bar relitigation of that issue in this subsequent claim because of the Fourth Circuit's intervening decision in *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 22 B.L.R. 2-162 (4th Cir. 2000). The existence of pneumoconiosis may be established by any one or more of the following methods: (1) chest x-rays; (2) autopsy or biopsy; (3) by operation of presumption; or (4) by a physician exercising sound medical judgment based on objective medical evidence. 20 C.F.R. § 718.202(a). Because this claim arises within the territorial jurisdiction of the Fourth Circuit, the adjudicator must weigh all of the evidence together in reaching a finding as to whether a miner has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d at 211. *See Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 21 B.L.R. 2-104 (3rd Cir. 1997).

Pneumoconiosis under the Act is defined as both clinical pneumoconiosis and/or any respiratory or pulmonary condition significantly related to or significantly aggravated by coal dust exposure:

> (a) For the purpose of the Act, ''pneumoconiosis'' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or ''clinical'', pneumoconiosis and statutory, or ''legal'', pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis.* ''Clinical pneumoconiosis'' consists of those diseases recognized by the medical community as pneumoconioses, *i.e.,* the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis.* ''Legal pneumoconiosis'' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

20 C.F.R. §§ 718.201(a)(1), (2).

In *Cornett v. Benham Coal Co.*, 227 F.3d 569, 575, 22 B.L.R. 2-107 (6th Cir.

2000)., the court emphasized that the "legal" definition of pneumoconiosis "'encompasses a wider range of afflictions than does the more restrictive medical definition of pneumoconiosis.'" (quoting *Kline v. Director*, *OWCP*, 877 F.2d 1175, 1178, 12 B.L.R. 2-346 (3d Cir. 1989)). *See Warth v. Southern Ohio Coal Co.*, 60 F.3d 173, 174, 19 BLR 2-265 (4th Cir. 1995). *See also Mitchell v. OWCP*, 25 F.3d 500, 507 n.12, 18 BLR 2-257 (7th Cir 1994); *Eagle v. Armco Inc.*, 943 F.2d 509, 511 n.2, 15 BLR 2-201 (4th Cir. 1991); *Old Ben Coal Co. v. Prewitt*, 755 F.2d 588, 591 (7th Cir. 1985) (chronic obstructive pulmonary disease meets statutory definition whether or not technical pneumoconiosis). Again, however, an obstructive pulmonary or respiratory impairment must be proven to have been significantly related to or substantially aggravated by Claimant's coal mine dust exposure. *See Stiltner v. Island Creek Coal Co.*, 86 F.3d 337, 341, 20 BLR 2-246 (4th Cir. 1996). *See generally* 65 Fed. Reg. 79943 (Dec. 20, 2000) (citing cases). Moreover, it must be emphasized that a finding that clinical pneumoconiosis has not been established does not preclude a finding of legal pneumoconiosis. *Cf. Consolidation Coal Co. v. Director, OWCP* [*Stein*], 294 F.3d 885, 892-93, 22 BLR 2-409 (7th Cir. 2002) (negative CT scan does not rule out legal pneumoconiosis).

20 C.F.R. § 718.202(a)(1)

The regulation at 20 C.F.R. § 718.202(a)(1) requires that "where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays."[9] In this vein, the Board has held that it is proper to accord greater weight to the interpretation of a B-reader or Board-certified radiologist over that of a physician without these specialized qualifications. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Allen v. Riley Hall Coal Co.*, 6 B.L.R. 1-376 (1983). Moreover, an interpretation by a dually-qualified B-reader and Board-certified radiologist may be accorded greater weight than that of a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Sheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128 (1984). *Accord*, *Zeigler Coal Co. v. Director*, *OWCP* [*Hawker*], 326 F.3d 894, 899, __ B.L.R. 2-___ (7th Cir. 2003). Finally, a radiologist's academic teaching credentials in the field of radiology are relevant to the evaluation of the weight to be assigned to that expert's conclusions. *See Worhach v. Director*, *OWCP*, 17 B.L.R. 1-105 (1993). I emphasize, however, that the adjudicator is not required to defer to the interpretations by a radiologist who holds an academic position or professorship. *See Chaffin v. Peter Cave Coal Co.*, 22 B.L.R. 1-294 (2003). The party seeking to rely on an x-ray interpretation bears the burden of establishing the qualifications of the reader. *Rankin v. Keystone Coal Mining Co.*, 8 B.L.R. 1-54 (1985).

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[9] A "B-reader" (B) is a physician, but not necessarily a radiologist, who successfully completed an examination in interpreting x-ray studies conducted by, or on behalf of, the Appalachian Laboratory for Occupational Safety and Health (ALOSH). A designation of "Board-certified" (BCR) denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association.

The employer suggests that, because two prior administrative law judges have found that the x-ray evidence does not demonstrate the presence of pneumoconiosis, "the readings of x-rays prior to 1999 are negative[.]" Brief at 10. I disagree. First, Judge Hillyard acknowledged that Judge Tureck found pneumoconiosis established, and evaluated the duplicate claim before him on the basis of whether the Claimant had established a material change by proving total respiratory disability. DX-3 (No. 1998-BLA-0509, Decision and Order at 13). More important, the requirement, that the entire administrative record must be considered when a claimant meets the "material change" threshold, means just that – a *de novo* review of the evidence.

Upon review of the x-ray evidence of record, however, I find that the Claimant has not demonstrated the presence of pneumoconiosis at Section 718.202(a)(1). I consider the record x-ray evidence to be equally probative. Of the two newly submitted films, I find that the January 20, 2002 x-ray is negative. In so doing, I shall defer to the negative interpretation of this x-ray by Dr. Wheeler on the basis of his superior credentials, notwithstanding Dr. Alexander's academic and clinical experience. *See Worhach*. I also find that the October 14, 2003 film demonstrates the presence of pneumoconiosis based on the preponderance of the positive x-ray interpretations.

An administrative law judge is not required to defer to the numerical superiority of x-ray evidence. *Wilt v. Wolverine Mining Co*., 14 B.L.R. 1-70 (1990). *See also Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1984). Moreover, the adjudicator should not blindly defer to later x-rays, especially where an earlier film is positive. *See Adkins v. Director*, *OWCP*, 958 F.2d 49, 16 B.L.R. 2-61 (4th Cir. 1992). Nevertheless, I find that the October 14, 2003 film is positive for pneumoconiosis. *See generally Napier v. Director, OWCP*, 890 F.2d 669, 671, 13 B.L.R. 2-117 (4th Cir. 1989) (rational basis for ALJ to resolve conflicting interpretations of x-rays by deferring to rereadings by B-readers); *Edmiston v. F&R Coal Co.* 14 B.L.R. 1-65 (1990). The latter film was interpreted as positive not only by Dr. Alexander, but also by three other dually-credentialed radiologists.

Turning to the earliest films taken between 1984 and 1990, however, I find that those x-rays on balance do not demonstrate pneumoconiosis. Although the Claimant secured a number of positive readings, the negative rereadings of the films taken on September 21, 1984 and April 23, 1987 by Drs. Sargent and Gaziano, as well as those of the August 28, 1987 and February 20, 1990 x-rays render the x-ray evidence of pneumoconiosis at that stage equally probative, despite the unanswered positive reading by Dr. Speiden. For the third claim, the record contains numerous positive readings of the December 3, 1997 x-ray. I find this to be a positive film, despite the negative rereading by the exceptionally well qualified Dr. Wiot. I also find, however, that x-rays taken on September 1, 1998 June 27 and February 20, 1997, are negative. Overall the x-ray evidence is at best equally probative.

In the final analysis, having conducted a "qualitative," as well as a quantitative evaluation of the x-ray readings, *see Woodward v. Director, OWCP*, 991 F.2d 314, 321, 17 B.L.R. 2-77 (6th Cir. 1993), I find that Claimant has not demonstrated

pneumoconiosis at Section 718.202(a)(1) by a preponderance of the x-ray evidence.

20 C.F.R. § 718.202(a)(iv)

There is no relevant biopsy or autopsy evidence. I therefore address the question of whether the Claimant has demonstrated the existence of pneumoconiosis on the basis of a reasoned medical opinion diagnosis of the disease. 20 C.F.R. § 718.202(a)(4).

I note that the Claimant has offered the opinions of Dr. Rasi, who has treated him for many years. The Secretary's regulations provide, with respect to the opinions of a treating physician:

20 C.F.R. § 718.104(d)(1) - (4). The regulations also provide that:

> In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudicative officer's decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole.

20 C.F.R. § 718.104(d)(5). A physician's analysis must be based on adequate documentation. *See Lane v. Union Carbide Corp*., 105 F.3d at 172. *See generally Lango v. Director*, *OWCP*, 104 F.3d 573, 576, 21 B.L.R. 2-12 (3d Cir. 1997).

In the final analysis, the credibility of the treating physician's opinion may primarily rest on its "power to persuade." *Eastover Mining Co. v. Williams*, 338 F.3d 501, 513, 22 B.L.R. 2-625 (6th Cir. 2003). If a treating physician's opinion is not credible, an administrative law judge need not accord additional weight to the treating physician's opinion. *See* 20 C.F.R. § 718.104(d)(5). *See also Jericol Mining, Inc. v. Napier*, 311 F.3d 703 (6th Cir. 2002); *Wolfe Creek Collieries v. Director, OWCP* [*Stephens*], 298 F.3d 511 (6th Cir. 2002); *Peabody Coal Co. v. Groves*, 277 F.3d 834, 22 B.L.R. 2-320 (6th Cir. 2002).

With this in mind, I accord little weight to the diagnostic opinions from Dr. Rasi. Although his observations of the Claimant's pulmonary or respiratory symptoms are important to buttress assessments that Mr. Rushbrook has become totally disabled from a pulmonary or respiratory standpoint, his conclusions, that the Claimant suffers from pneumoconiosis, are not adequately documented or persuasively reasoned. Dr. Rasi, while treating the Claimant for years, appears to "carry" a diagnosis of pneumoconiosis by history throughout many of his reports. There is no adequate explanation for the diagnosis of pneumoconiosis in the treatment records. Also, as Dr. Hippensteel notes, Dr. Rasi does not adequately account for other sources for the Claimant's respiratory problems, such as his coronary artery disease and his significant smoking history. *See*

DX-15. In addition, Dr. Hippensteel concluded that the records demonstrate a "variable," rather than "fixed," obstructive airways disease, which he thought would not be typical for coal workers' pneumoconiosis. Dr. Branscomb likewise saw in the records intermittent manifestations of chronic bronchitis with "intermittent transient reductions in PO2." EX-6. I credit these findings, as well as their suggestions that this variability cuts against a finding of pneumoconiosis or any coal mine dust related disease.

The strongest evidence in support of the claim is the medical report and opinion by Dr. Koenig.[10] Although Dr. Koenig's report is thoroughly explained and his conclusions analyzed, I find that his diagnosis of pneumoconiosis, and attribution of the Claimant's chronic obstructive pulmonary disease, is not sufficiently persuasive to demonstrate the existence of that disease. Dr. Koenig spends a considerable amount of effort in analyzing the chest x-ray results and pulmonary function tests. One serious flaw in Dr. Koenig's analysis involves his views regarding the persistent effects of smoking. While he discounts the effects of smoking long after the cessation of that habit, Drs. Hippensteel and Forehand would take a contrary view, with the latter actually attributing the Claimant's COPD to smoking. Moreover, in his deposition testimony on October 1, 1998, Dr. Rasmussen acknowledged that smoking was a risk factor, along with coal mine dust exposure. Dr. Branscomb also said that the adverse effects of tobacco do not stop with cessation, but progresses at a slower rate.

Because Dr. Koenig's treatment of the effects of smoking is not persuasive, I find that his diagnosis of COPD derived from coal mine dust exposure, on balance, does not demonstrate the presence of pneumoconiosis. *See generally Bobick v. Saginaw Mining Co.*, 13 B.L.R. 1-52 (1988); *Maypray v. Island Creek Coal Co.*, 7 B.L.R. 1-683 (1983).

20 C.F.R § 718.202(a)

In view of the findings that the Claimant has failed to demonstrate the existence of pneumoconiosis under any specific subsection, I must find that pneumoconiosis has not been established. *Compton.*

[10] Again, Dr. Rasi's diagnoses of pneumoconiosis appear primarily as references to history. Drs. Strain and England likewise do not render persuasive diagnoses of the disease. Understandably, the treatment of the Claimant is primarily directed to his coronary disease, although I note he was admitted after his surgery with respiratory symptoms on March 26, 1997. He had complained of shortness of breath in the three days prior to admission. This hospitalization followed his February, 1997, bypass surgery. Dr. Vasudevan detected normal breath sounds and mild expiratory wheezes. Other signs relevant to the presence of a pulmonary condition, such as extremities, were normal. Dr. Vasudevan diagnosed an exacerbation of chronic obstructive pulmonary disease. CX-1. On admission, the Clamant had denied the use of tobacco. When he examined the Claimant for the Department of Labor, Dr. Vasudevan attributed the Claimant's pulmonary impairment to smoking. DX-3 [DX-13].

Disability Causation

Assuming that the Claimant has established that he suffers from pneumoconiosis, I nevertheless find that he has not proven disability causation. Benefits are provided under the Act for, or on behalf of, miners who are totally disabled due to pneumoconiosis. 20 C.F.R. § 718.204(a) (2004). Pneumoconiosis must be a "substantially contributing cause" to the miner's total disability. 20 C.F.R. § 718.204(c)(1) (2004). The regulations define "substantially contributing cause" as follows:

> (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or
>
> (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

20 C.F.R. § 718.204(c)(1) (2004).

Upon review of the record as a whole, I find that the Claimant would not establish disability causation at Section 718.204(c). I do not accord great weight to the opinions, including those of Drs. Rasmussen, Rasi and Koenig, that pneumoconiosis is a substantial contributor to the Claimant's total disability. Even accepting their diagnoses of pneumoconiosis, I nonetheless find that their causation opinions provide scant analysis, or recognition of, the effects of a very lengthy smoking history of at least 40 pack/years. *Cf. Peabody Coal Co. v. Hill*, 123 F.3d 412, 417, 21 BLR 1-192 (6th Cir. 1997) (administrative law judge rejected opinions that failed to discount persuasively exposure effects of coal mine employment).

I also credit Dr. Branscomb's[11] view that coronary artery disease, myocardial infarction and esophageal disease may represent causes of pulmonary impairment. The fact that these factors are not thoroughly addressed by Dr. Koenig[12] detracts from the probative weight of his causation opinion. Further, I credit Dr. Hippensteel's view that an obstructive disease from smoking progresses more than that derived from pneumoconiosis. In addition, I find that Dr. Forehand's opinion with respect to disability causation, as supported by an examination and clinical testing, when combined with the opinions of Drs. Branscomb and Hippensteel, all preclude proof of disability causation in this instance.[13]

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[11] I am also crediting Dr. Branscomb's opinions based on his credentials.

[12] While recognizing that Dr. Koenig has impressive academic credentials, I defer to the opinions of Dr. Hippensteel because of his clinical experience, the fact that he is board certified in internal and pulmonary medicine, and because he examined the Claimant as well as reviewed his medical records.

[13] I do not accept Dr. Hippensteel's discussions with regard to the significance of a positive interpretation of pneumoconiosis as set forth in an ILO form for recording a chest x-ray reading.

In the final analysis, I am unable to find that the Claimant has established disability causation by a preponderance of the evidence. Because the Claimant has not established either pneumoconiosis or disability causation, he is not entitled to benefits under the Act.

ATTORNEY'S FEES

The award of an attorney's fee under the Act is permitted only in cases in which the Claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim of Albert L. Rushbrook benefits under the Act is denied.

A

WILLIAM S. COLWELL
Administrative Law Judge

Washington, D.C.
WSC:dj

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed. At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S.

See EX-8 at 36-38. Nevertheless, this discussion has no bearing on the probative value of his other conclusions.

Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).